

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WELLBROOKE OF AVON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10307 EAST COUNTY ROAD 100 NORTH</b> <b>INDIANAPOLIS, IN 46234</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00159385 completed on November 13, 2014.</p> <p>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on November 13, 2014.</p> <p>Complaint IN00159385 - corrected</p> <p>Survey date: December 30, 2014.</p> <p>Facility number: 013085 Provider number: 155811 AIM number: N/A</p> <p>Survey Team: Kewanna Gordon, RN-TC Lora Brettnacher, RN Tracina Moody, RN</p> <p>Census bed type: SNF: 29 SNF/NF: 10 Residential: 9 Total: 48</p> <p>Census Payor type: Medicare: 29 Other: 10 Total: 39</p> <p>Sample: 3</p> <p>Wellbrooke of Avon was found to be in compliance with 42 CFR Part 483, Subpart B and</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 410 IAC 16.2-3.1 in regards to the PSR to Complaint IN00159385.  Quality review completed 1/2/15 by Brenda Marshall, RN.	{F 000}			